

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0037044

**Facility Name:** Lincoln Square

**Address:** 202 South Main Street Jonesboro 62952  
 Number City Zip Code

**County:** Union

**Telephone Number:** (618) 833-2063 **Fax #** (618) 833-4993

**HFS ID Number:** 371272697001

**Date of Initial License for Current Owners:** 01/06/1988

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Richard Stroh **Telephone Number:** (618) 833-5070x11

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number Lincoln Square

# 0037044 Report Period Beginning: 01/01/06 Ending: 12/31/06

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5475

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>15</u>	ICF/DD 16 or Less	<u>15</u>	<u>5,475</u>	6
7	<u>15</u>	TOTALS	<u>15</u>	<u>5,475</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,460</u>			<u>5,460</u>
14	TOTALS	<u>5,460</u>			<u>5,460</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.73%

D. How many bed-hold days during this year were paid by the Department?

15 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1991

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 01/01/1991 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/06 Ending: 12/31/06

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	24,345	2,149	1,223	27,717		27,717		27,717		1
2	Food Purchase		44,929		44,929		44,929	(959)	43,970		2
3	Housekeeping	11,507	4,075	820	16,402		16,402	66	16,468		3
4	Laundry		470		470		470		470		4
5	Heat and Other Utilities			13,784	13,784		13,784	242	14,026		5
6	Maintenance		2,116	1,381	3,497		3,497	5,231	8,728		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>35,852</b>	<b>53,739</b>	<b>17,208</b>	<b>106,799</b>		<b>106,799</b>	<b>4,580</b>	<b>111,379</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	149,688	3,864	1,639	155,191		155,191	932	156,123		10
10a	Therapy		801	6,179	6,980		6,980		6,980		10a
11	Activities	18,953		463	19,416		19,416		19,416		11
12	Social Services		3,051	2,963	6,014		6,014	(2,517)	3,497		12
13	CNA Training	8,014		735	8,749		8,749		8,749		13
14	Program Transportation		1,571	2,927	4,498		4,498	361	4,859		14
15	Other (specify):* <b>Day Training</b>			132,570	132,570		132,570	(132,570)			15
16	<b>TOTAL Health Care and Programs</b>	<b>176,655</b>	<b>9,287</b>	<b>151,076</b>	<b>337,018</b>		<b>337,018</b>	<b>(133,794)</b>	<b>203,224</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			8,400	8,400		8,400	4,553	12,953		17
18	Directors Fees							524	524		18
19	Professional Services			27,155	27,155		27,155	(23,917)	3,238		19
20	Dues, Fees, Subscriptions & Promotions			2,163	2,163		2,163	(542)	1,621		20
21	Clerical & General Office Expenses	6,705	3,813	4,320	14,838		14,838	6,474	21,312		21
22	Employee Benefits & Payroll Taxes			34,530	34,530		34,530	4,078	38,608		22
23	Inservice Training & Education			534	534		534		534		23
24	Travel and Seminar							93	93		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			2,674	2,674		2,674	157	2,831		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>6,705</b>	<b>3,813</b>	<b>79,776</b>	<b>90,294</b>		<b>90,294</b>	<b>(8,580)</b>	<b>81,714</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>219,212</b>	<b>66,839</b>	<b>248,060</b>	<b>534,111</b>		<b>534,111</b>	<b>(137,794)</b>	<b>396,317</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lincoln Square #0037044 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			4,041	4,041	4,041	11,751	15,792			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			162	162	162	2,515	2,677			32
33	Real Estate Taxes			6,623	6,623	6,623	110	6,733			33
34	Rent-Facility & Grounds			48,300	48,300	48,300	(47,825)	475			34
35	Rent-Equipment & Vehicles			90	90	90	205	295			35
36	Other (specify):* <a href="#">See Page 25</a>			1,504	1,504	1,504	(1,504)				36
37	<b>TOTAL Ownership</b>			60,720	60,720	60,720	(34,748)	25,972			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			22,557	22,557	22,557		22,557			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			22,557	22,557	22,557		22,557			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	219,212	66,839	331,337	617,388	617,388	(172,542)	444,846			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (132,570)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(38)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,439	30		9
10	Interest and Other Investment Income	(162)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(410)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(624)	36		24
25	Fund Raising, Advertising and Promotional	(67)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(880)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(3,571)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (126,883)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,659)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (45,659)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (172,542)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Lincoln Square

ID# 0037044  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Expense Offset by Revenues	\$ (959)	2	1
2	Contributions	(32)	12	2
3	Tobacco	(218)	12	3
4	Flowers	(40)	12	4
5	Clothing	(2,227)	12	5
6	PAC Dues	(72)	20	6
7	Chamber Dues	(23)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,571)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06

Ending:

12/31/06

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(959)	0	0	0	0	0	0	0	0	0	0	(959)	2
3	Housekeeping	0	66	0	0	0	0	0	0	0	0	0	66	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	242	0	0	0	0	0	0	0	0	0	242	5
6	Maintenance	0	318	4,913	0	0	0	0	0	0	0	0	5,231	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(959)</b>	<b>626</b>	<b>4,913</b>	<b>0</b>	<b>4,580</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	932	0	0	0	0	0	0	0	0	932	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(2,517)	0	0	0	0	0	0	0	0	0	0	(2,517)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	361	0	0	0	0	0	0	0	0	0	361	14
15	Other (specify):*	(132,570)	0	0	0	0	0	0	0	0	0	0	(132,570)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(135,087)</b>	<b>361</b>	<b>932</b>	<b>0</b>	<b>(133,794)</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	4,553	0	0	0	0	0	0	0	0	4,553	17
18	Directors Fees	0	524	0	0	0	0	0	0	0	0	0	524	18
19	Professional Services	0	83	(24,000)	0	0	0	0	0	0	0	0	(23,917)	19
20	Fees, Subscriptions & Promotions	(572)	30	0	0	0	0	0	0	0	0	0	(542)	20
21	Clerical & General Office Expenses	0	1,123	5,351	0	0	0	0	0	0	0	0	6,474	21
22	Employee Benefits & Payroll Taxes	(38)	4,116	0	0	0	0	0	0	0	0	0	4,078	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	93	0	0	0	0	0	0	0	0	0	93	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	157	0	0	0	0	0	0	0	0	0	157	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(610)</b>	<b>6,126</b>	<b>(14,096)</b>	<b>0</b>	<b>(8,580)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(136,656)</b>	<b>7,113</b>	<b>(8,251)</b>	<b>0</b>	<b>(137,794)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06 Ending:

12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	11,439	312	0	0	0	0	0	0	0	0	0	11,751	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(162)	0	2,677	0	0	0	0	0	0	0	0	2,515	32
33	Real Estate Taxes	0	110	0	0	0	0	0	0	0	0	0	110	33
34	Rent-Facility & Grounds	0	0	(47,825)	0	0	0	0	0	0	0	0	(47,825)	34
35	Rent-Equipment & Vehicles	0	0	205	0	0	0	0	0	0	0	0	205	35
36	Other (specify):*	(1,504)	0	0	0	0	0	0	0	0	0	0	(1,504)	36
37	<b>TOTAL Ownership</b>	<b>9,773</b>	<b>422</b>	<b>(44,943)</b>	<b>0</b>	<b>(34,748)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(126,883)</b>	<b>7,535</b>	<b>(53,194)</b>	<b>0</b>	<b>(172,542)</b>	<b>45</b>							

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jacob L. Alley	50	Mulberry Manor	Anna	JR's Centre	Anna	Workshop
Diana Ally	50	Holly Hill	Anna	kel-Tech Mgmt Co	Anna	Acct/Mgmt
		Glen Brook	Vienna	ILS 1-3	Anna	CILA
		Pilot House	Cairo	ILS 4	Metropolis	CILA
		Krypton	Metropolis	LS Land Trust	Anna	Land Trust
		Liberty House	Marion			
		New Way	Anna			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 66	\$ 66	1	
2	V	5 Utilities		kel-Tech Management Co.	25.00%	242	242	2	
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	318	318	3	
4	V	14 Transportation		kel-Tech Management Co.	25.00%	361	361	4	
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	524	524	5	
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	83	83	6	
7	V	20 Dues, Fees, Subscription		kel-Tech Management Co.	25.00%	30	30	7	
8	V	21 Clerical & General Office		kel-Tech Management Co.	25.00%	1,123	1,123	8	
9	V	22 Employee Benefits & Taxes		kel-Tech Management Co.	25.00%	4,116	4,116	9	
10	V	24 Inservice Training		kel-Tech Management Co.	25.00%	93	93	10	
11	V	26 Insurance		kel-Tech Management Co.	25.00%	157	157	11	
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	110	110	12	
13	V	30 Depreciation		kel-Tech Management Co.	25.00%	312	312	13	
14	Total		\$			\$ 7,535	\$ *	7,535	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/06Ending: 12/31/06

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	\$	kel-Tech Management Co.	25.00%	\$ 475	\$ 475	15
16	V	35	Equipment Rental		kel-Tech Management Co.	25.00%	205	205	16
17	V	10	Nursing		kel-Tech Management Co.	25.00%	932	932	17
18	V	17	Administration		kel-Tech Management Co.	25.00%	4,553	4,553	18
19	V	21	Clerical		kel-Tech Management Co.	25.00%	5,351	5,351	19
20	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,913	4,913	20
21	V								21
22	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	22
23	V	34	Building Lease	48,300	Lincoln Square Land Trust	100.00%		(48,300)	23
24	V	32	Building Interest		Lincoln Square Land Trust	100.00%	2,677	2,677	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 72,300			\$ 19,106	\$ * (53,194)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Diana Alley	DON/ Owner	DON	50.00	27,662	8	20.00	Nursing	\$ 24,095	10-1	1
2	Jacob L. Alley	Owner		50.00							2
3											3
4											4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation:										7
8	Diana Alley							Nursing	932	10-1	8
9	Jacob L. Alley							Maintenance	3,496	6-1	9
10	James A. Keller							Admin	4,553	17-1	10
11											11
12											12
13								TOTAL	\$ 33,076		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization kel-Tech Mgmt Co  
 Street Address 158 E. Vienna Street  
 City / State / Zip Code Anna, IL 62906  
 Phone Number (618) 833-5070  
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contribution	363,999	12	\$ 1,008	\$ 24,000	\$ 66	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	363,999	12	3,312	24,000	218	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	363,999	12	369	24,000	24	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	363,999	12	498	24,000	33	4
5	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	363,999	12	748	24,000	49	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	363,999	12	292	24,000	19	6
7	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	363,999	12	1,474	24,000	97	7
8	6	REPAIRS BLDG-B	Mgmt Fee Contribution	363,999	12	284	24,000	19	8
9	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	363,999	12	1,536	24,000	101	9
10	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	363,999	12	721	24,000	48	10
11	14	TRANSPORTATION-B	Mgmt Fee Contribution	363,999	12	4,754	24,000	313	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contribution	363,999	12	7,950	24,000	524	12
13	19	CONTRACT SERVICES	Mgmt Fee Contribution	363,999	12	455	24,000	30	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	363,999	12	810	24,000	53	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	363,999	12	452	24,000	30	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	363,999	12	144	24,000	10	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	363,999	12	0	24,000	0	17
18	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	363,999	12	122	24,000	8	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	363,999	12	191	24,000	13	19
20	21	G & A MISC-B	Mgmt Fee Contribution	363,999	12	288	24,000	19	20
21	21	G & A MISC-B:88210 · SUPPLIE	Mgmt Fee Contribution	363,999	12	158	24,000	10	21
22	21	G & A SUPPLIES-B	Mgmt Fee Contribution	363,999	12	7,730	24,000	510	22
23	21	POSTAGE-B	Mgmt Fee Contribution	363,999	12	3,086	24,000	203	23
24	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	363,999	12	891	24,000	59	24
25	TOTALS					\$ 37,273	\$	\$ 2,456	25

Facility Name & ID Number Lincoln Square

# 0037044 Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization kel-Tech Mgmt Co  
 Street Address 158 E. Vienna Street  
 City / State / Zip Code Anna, IL 62906  
 Phone Number (618) 833-5070  
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	TELEPHONE-B	Mgmt Fee Contribution	363,999	12	\$ 2,367	\$ 24,000	\$ 156	1	
2	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	363,999	12	1,641	24,000	108	2	
3	21	UTILITIES-INTERNET	Mgmt Fee Contribution	363,999	12	408	24,000	27	3	
4	22	INS EMP GROUP-B	Mgmt Fee Contribution	363,999	12	40,061	24,000	2,641	4	
5	22	INSURANCE W/C-B	Mgmt Fee Contribution	363,999	12	2,664	24,000	176	5	
6	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	363,999	12	19,708	24,000	1,299	6	
7	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	363,999	12	1,406	24,000	93	7	
8	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	363,999	12	1,145	24,000	75	8	
9	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	363,999	12	1,246	24,000	82	9	
10	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	363,999	12	1,661	24,000	110	10	
11	30	DEPRECIATION	Mgmt Fee Contribution	363,999	12	4,731	24,000	312	11	
12	34	LEASE BLDG-B	Mgmt Fee Contribution	363,999	12	7,200	24,000	475	12	
13	35	LEASE EQUIP-B	Mgmt Fee Contribution	363,999	12	3,110	24,000	205	13	
14	10	Nursing	Mgmt Fee Contribution	363,999	12	14,140	14,140	24,000	932	14
15	17	Administration	Mgmt Fee Contribution	363,999	12	69,058	69,058	24,000	4,553	15
16	21	Clerical	Mgmt Fee Contribution	363,999	12	81,149	81,149	24,000	5,351	16
17	6	Maintenance	Mgmt Fee Contribution	363,999	12	74,519	74,519	24,000	4,913	17
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 326,215	\$ 238,866	\$ 21,508	25	

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	US Bank		X	Vehicle Loan	\$296.45	6/2/04	\$ 9,909	\$ 1,468	6/2/07	4.9000	\$ 162	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$296.45		\$ 9,909	\$ 1,468			\$ 162	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 9,909	\$ 1,468			\$ 162	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>6,800</b>	1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>6,516</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(284)</b>	3														
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>6,907</b>	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>6,623</b>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
	2001	<u>5,156</u>	<u>8</u>	<table border="1"> <tr> <td colspan="2"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2002	<u>5,218</u>	<u>9</u>																
	2003	<u>5,317</u>	<u>10</u>																
	2004	<u>6,624</u>	<u>11</u>																
	2005	<u>6,516</u>	<u>12</u>																
<u>Sch IX, Line 7</u>		<u>6623</u>																	
<u>kel-Tech Allocation</u>		<u>110</u>																	
<u>Sch V, Line 33, col. 8</u>		<u>6733</u>																	

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lincoln Square COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037044

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-00-07-353</u>	<u>Lot 69 Grammer's Addition</u>	\$ <u>5,631.28</u>	\$ <u>5,631.28</u>
2. <u>14-00-17-418</u>	<u>W 1/2 Lot 120 Grammer's Addition</u>	\$ <u>826.38</u>	\$ <u>826.38</u>
3. <u>14-00-07-408</u>	<u>Lot 111 Grammer's Addition</u>	\$ <u>58.60</u>	\$ <u>58.60</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>6,516.26</u>	\$ <u>6,516.26</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Lincoln Square

# 0037044 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 3,200 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	8,000	1987	\$ 7,800	1
2	Healthcare	7,056	2006	2,200	2
3	TOTALS	15,056		\$ 10,000	3

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15		2005	1987	\$ 231,909	\$	27.5	\$ 7,730	\$ 7,730	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Carpeting			1997	4,056		7	271	271	4,056	9
10	Living Room Carpwt			1998	571		7	57	57	571	10
11	Carpeting			2001	3,640		7	520	520	3,640	11
12	Tile Floor			2002	3,922	190	15	261	71	2,211	12
13	Fire Alarm Panel			2005	1,835	587	5	367	(220)	849	13
14	Wood Deck			2005	2,100	200	15	140	(60)	500	14
15	Tile Floor - Living Room			2006	2,177	82	15	54	(28)	82	15
16	Tile Floor - Hall			2006	2,804	35	15	23	(12)	35	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 253,014	\$ 1,094		\$ 9,423	\$ 8,329	\$ 11,944	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lincoln Square # 0037044 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,113	\$ 517	\$ 302	\$ (215)	7	\$ 819	71
72	Current Year Purchases	1,605	1,605	110	(1,495)	7	1,605	72
73	Fully Depreciated Assets	68,897		2,663	2,663	7	68,897	73
74								74
75	TOTALS	\$ 72,615	\$ 2,122	\$ 3,075	\$ 953		\$ 71,321	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	2001 Ford Van	2000	\$ 26,232	\$	\$	\$	5	\$ 26,232	76
77	Healthcare	2004 Ford Focus	2004	14,909	825	2,982	2,157	5	12,811	77
78										78
79										79
80	TOTALS			\$ 41,141	\$ 825	\$ 2,982	\$ 2,157		\$ 39,043	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 376,770	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,041	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,480	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,439	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,308	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 90

Description: Water Cooler Rental

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,042		1,042
4	Clinical Wages (b)		2,031		2,031
5	In-House Trainer Wages (c)		4,941		4,941
6	Transportation				
7	Contractual Payments		735		735
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,749	\$	\$ 8,749
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,749		

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>4</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 12,144	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	110,046		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	99,075		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 221,265	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	21,105		15
16	Equipment, at Historical Cost	113,756		16
17	Accumulated Depreciation (book methods)	(122,305)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <b>DSP Training Reimbursable</b>	69		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,625	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 233,890	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 6,116	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,645		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,791		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,907		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 23,459	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	6,468		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,468	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 29,927	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 203,963	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 233,890	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 170,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 170,444	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	52,231	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(18,712)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 33,519</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 203,963</b>	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Lincoln Square# 0037044Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 528,633	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 528,633	3
<b>B. Ancillary Revenue</b>			
4	Day Care	132,570	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 132,570	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,936	11
12	Gift and Coffee Shop	3,137	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,073	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	343	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 343	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 669,619	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	106,799	31
32	Health Care	337,018	32
33	General Administration	90,294	33
<b>B. Capital Expense</b>			
34	Ownership	60,720	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	22,557	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 617,388	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	52,231	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 52,231	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	416	416	\$ 24,095	\$ 57.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,151	2,240	18,953	8.46	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,193	2,282	24,345	10.67	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	861	862	6,705	7.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,045	2,085	40,543	19.45	29
30	Habilitation Aides (DD Homes)	12,627	12,905	104,571	8.10	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,293	20,790	\$ 219,212 *	\$ 10.54	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	27	\$ 1,223	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	37	2,190	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	85	2,963	12-3	45
46	Other(specify) <u>Dental Consultant</u>	24	1,200	10a-3	46
47	<u>Psychologist</u>	33	1,474	10a-3	47
48	<u>See Pg 25</u>	214	9,715		48
49	TOTAL (lines 35 - 48)	480	\$ 22,665		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number Lincoln Square

# 0037044

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 5,931	IDPH License Fee	\$	
				Unemployment Compensation Insurance	7,610	Advertising: Employee Recruitment		
				FICA Taxes	16,498	Health Care Worker Background Check		
				Employee Health Insurance	4,112	(Indicate # of checks performed <u>8</u> )	128	
				Employee Meals	38	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		kel-Tech Mgmt Allocation	30	
				Employment Physicals	341	See Pg 25	1,463	
TOTAL (agree to Schedule V, line 17, col. 1)			\$	kel-Tech Mgmt Co. Allocation	4,116			
(List each licensed administrator separately.)				Less Staff Meals	(38)	Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Cheryl Sherrill, Administrator Consultant			\$ 8,400					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 38,608	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,621	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 8,400	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Barnett & Levine	CPA		\$ 3,095				In-State Travel	
FMGR	Legal		60				Seminar Expense	
kel-Tech Management Co.	Accting/Mgmt Services		24,000				kel-Tech Mgmt Allocation	93
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
				TOTAL	\$		TOTAL	\$ 93
TOTAL (agree to Schedule V, line 19, column 3)			\$ 27,155					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Lincoln Square

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Healthcare Assoc. \$828
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 81 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Lincoln Square #0032469 1/6/88
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 22,557  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 38 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not required of this facility
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII  
 Owners Compensation  
 Jan 1, 2006 - Dec 31, 2006

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 110,449	23,871		3,462					43,171		39,945
Denise Pippins	\$ 70,869	26,149	7,500	25,050	12,170						
Diana Alley	\$ 111,497	12,015	36,000	9,600	15,647		24,095	14,140			
Jo Ann Keller	\$ 145,069			18,500	102,575	23,994					
James K. Keller	\$ 32,543			18,000	14,543						
Jacob Alley	\$ 53,045							53,045			
Jake Alley	\$ 37,527		37,527								
James A. Keller	\$ 100,019		20,150					69,058		10,811	
	\$ 661,018	\$ 62,035	\$ 101,178	\$ 74,612	\$ 144,935	\$ 23,994	\$ 24,095	\$ 136,243	\$ 43,171	\$ 10,811	\$ 39,945

Lincoln Square  
 Sch. XVIII B  
 Additional Detail Consultants  
 2006

	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Psychiatrist	5	400	10a-3
Behavioral Consultant	18	915	10a-3
Administrative Consultant	191	8,400	17-3
Total	214	9,715	

Lincoln Square  
 Analysis of Sch XIX, Section F.  
 2006

Resident Acct Bond Renewal	\$	240
Subscriptions		144
Food Sanitation License		70
IL Health Care Assoc Dues		828
P.O. Box Rental		13
IL Corp Ann Report		130
Help Wanted Advertising		38
Advertising		67
Contributions		410
Chamber Dues		23
IHCA PAC Dues		72

Less:

Chamber Due	(23)
Advertising	(67)
Contributions	(410)
IHCA PAC Dues	(72)
	<u>\$ 1,463</u>

Lincoln Square  
 Reconciliation of Book & Tax Income  
 2006

Adjusted Book Income	\$	52,231
Adjustment for Accrual Changes for 2006		(39,760)
Taxable Income Federal Income Sch K, Line 18	\$	<u>12,471</u>

Lincoln Square  
 Reconciliation of Depreciation  
 Sch V, Line 30, Col. 8 to Sch IX, Line 83, Col. 2

Sch IX	\$	15,480
kel-Tech Mgmt. Co. Alloc.		312
Sch V	\$	<u>15,792</u>

Lincoln Square  
 Detail of Sch. V, Line 36, Col. 3  
 2006

Bad Debt	\$	624
State Income Tax		880
Total	\$	<u>1,504</u>